

11197

## 11191 CERTIFICATE OF DEATH

Reg. Dist. No. 281

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Marys</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Marys</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Dameron</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Dameron</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>				STREET ADDRESS (If rural give location) <b>Rural</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Alexander M. Barnes</b>				<b>4. DATE OF DEATH</b> <b>11 / 25 / 19 55</b>			
<b>5. SEX</b> <b>male</b>		<b>6. COLOR OR RACE</b> <b>colored</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>married</b>		<b>8. DATE OF BIRTH</b> <b>9/22/ 1888</b>	
<b>9. AGE last birthday</b> <b>67</b> yrs.		<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Inspector Insurance Co.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Insurance Co.</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>Maryland</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>Daniel O. Barnes</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Josephine O. Barnes</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>-----</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Blanch E. Barnes - Dameron, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>450.0 IMMEDIATE CAUSE (A)</b> <b>Coronary Heart Failure</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 years</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Arteriosclerosis</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>0</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 11-15, 1955, to 11-25, 1955, that I last saw the deceased alive on 11-15, 1955, and that death occurred at M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>[Signature]</i>				<b>ADDRESS (Street, city, town, state)</b> <b>M.D. Trust Mills Rd</b>		<b>DATE SIGNED</b> <b>11-26-55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>11/29/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St. Peters Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Ridge, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>11-29-55</b>		<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>[Signature]</i>		<b>ADDRESS</b> <b>Leonardtown, Md.</b>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The bottom copy may be retained by the hospital or attending physician. The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

# 1901 CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BOSTON, MASS.

NAME	AGE	SEX	RACE	DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH

CAUSE OF DEATH	DIAGNOSIS	PERIOD OF ILLNESS	PREVAILING DISEASE	PREVAILING WEATHER	PREVAILING SEASON	PREVAILING TIME	PREVAILING PLACE

NAME OF PHYSICIAN	NAME OF NURSE	NAME OF ATTENDING PHYSICIAN	NAME OF ATTENDING NURSE	NAME OF ATTENDING PHYSICIAN	NAME OF ATTENDING NURSE	NAME OF ATTENDING PHYSICIAN	NAME OF ATTENDING NURSE

BUREAU V. S.

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11192 **CERTIFICATE OF DEATH**

11198

Reg. Dist. No. 287

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Marys</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Marys</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Leonardtwn</b>		LENGTH OF STAY (in this place) <b>1 wk.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Valley Lee</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>St. Marys Hospital</b>				STREET ADDRESS (If rural give location) <b>Rural</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Doctor William Briscoe</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>11 / 28 / 19 55</b>			
<b>5. SEX</b> <b>male</b>		<b>6. COLOR OR RACE</b> <b>colored</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>widowed</b>		<b>8. DATE OF BIRTH</b> <b>? - ? 1880</b>	
				<b>9. AGE last birthday</b> <b>75</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days	
						<b>11. IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>labor</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Benjamin Briscoe</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> -----		<b>17. INFORMANT &amp; ADDRESS</b> <b>Garfield Briscoe - Valley Lee, Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>							
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>331X IMMEDIATE CAUSE (A)</b> <b>Cerebral hemorrhage</b>							
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Generalized arterio-sclerosis</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>0</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>				<b>21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from Nov-23 1953 to Nov-28 1955, that I last saw the deceased alive on Nov-27 1955, and that death occurred at 4 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>[Signature]</i>				<b>ADDRESS (Street, city, town, state)</b> <i>[Address]</i>		<b>DATE SIGNED</b> <b>11/29/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>11/30/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St. Marks Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Valley Lee, Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>Nov 29/55</b>		<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>[Signature]</i>		<b>ADDRESS</b> <b>Leonardtwn, Md.</b>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1198

# CERTIFICATE OF DEATH

Name of Deceased [Faint text]		Sex [Faint text]		Date of Birth [Faint text]	
Usual Residence [Faint text]		Place of Birth [Faint text]		Date of Death [Faint text]	
Cause of Death [Faint text]		Manner of Death [Faint text]		Physician's Signature [Faint text]	
Burial Place [Faint text]		Date of Burial [Faint text]		Registrar's Signature [Faint text]	

This certificate is to be filled out by the attending physician or the coroner, and is to be filed in the office of the Registrar of Vital Statistics, State Department of Health, Boston, Massachusetts. It is to be used for the purpose of recording the death of a person, and for the purpose of determining the cause of death. It is to be filled out in duplicate, and the original is to be filed in the office of the Registrar of Vital Statistics, and the duplicate is to be filed in the office of the attending physician or the coroner.

**RECEIVED**  
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11193 **CERTIFICATE OF DEATH**

11199

Reg. Dist. No. 281

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Mary's</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Mary's</b>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<b>X</b> TOWN <b>Hermanville</b>		<b>Life</b>		TOWN <b>Hermanville</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>				STREET ADDRESS (If rural give location) <b>1</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <b>John</b> (Middle) <b>Harry</b> (Last) <b>Campbell</b>				<b>Nov. 16, 1955</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>Male</b>	<b>White</b>	<b>Married</b>	<b>August 12, 1907</b>	<b>48</b> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>Laborer</b>		<b>Day Work</b>		<b>Maryland</b>		<b>U.S.A.</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>Hazel Campbell</b>				<b>Jannie R. Bryan</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>Yes</b>				<b>Hazel Campbell Hermanville, Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>15 minutes</b>	
IMMEDIATE CAUSE (A) <b>Coronary occlusion</b>							
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <b>Enterocolitis</b>						<b>3 days</b>	
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
		<b>M.</b>					
<b>22. I hereby certify that I attended the deceased from</b> <b>Aug 15, 1955</b> <b>to</b> <b>Nov 16, 1955</b> , <b>that I last saw the deceased alive on</b> <b>Nov 15, 1955</b> , <b>and that death occurred at</b> <b>3:00A</b> <b>M.</b> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<b>11/17/55</b>				<b>Medley Neck, Md.</b>		<b>11/17/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>Burial</b>		<b>11/19/55</b>		<b>Our Lady's</b>		<b>Medley Neck, Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>DATE</b> <b>11/17/55</b>		<b>Local Registrar</b>		<b>Joe C. Mattingly</b>		<b>Lionardtown, Md</b>	

INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled in by the funeral director, the third copy of this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11200

11194

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St Mary's</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Mary's</b>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <b>X Leonardtown</b>		LENGTH OF STAY (in this place) <b>2 days</b>		CITY (If outside corporate limits, write RURAL end give nearest town) <b>Great Mills</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>78 St Mary's Hospital</b>				STREET ADDRESS (If rural give location) <b>/</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Infant Boy Cecil</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Nov. 4, 1955</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Single</b>	<b>8. DATE OF BIRTH</b> <b>Nov. 2, 1955</b>		<b>9. AGE last birthday</b> yrs. <b>2</b>		<b>IF UNDER 1 YEAR</b> Months <b>2</b> Days <b>2</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>	
<b>13. FATHER'S NAME</b> <b>Norbert J. Cecil</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Hospital Record</b>	
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>1 day</b>	
<b>762.0 IMMEDIATE CAUSE (A)</b> <b>cerebral anoxia</b>							
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>massive infarction</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <b>11-3-55</b>				<b>21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from 11-3-55, 1955 to 11-4-55, 1955 that I last saw the deceased alive on 11-3-55, 1955, and that death occurred at 6:42 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>[Signature]</i>				<b>ADDRESS</b> (Street, city, town, state) <b>Great Mills, Md.</b>		<b>DATE SIGNED</b> <b>11-4-55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Nov. 4, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Holy Face</b>		<b>LOCATION</b> (City, town, or county) (State) <b>Great Mills, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>[Signature]</i>		<b>ADDRESS</b> <b>Leonardtown, Md.</b>	
<b>DATE</b> <b>11-7-55</b>		<b>20X5901415</b>					

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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Item 18 Film G189 11-29-55

## 11195 CERTIFICATE OF DEATH

Reg. Dist. No. 282

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Mary's</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Mary's</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Leonardtwn</b>		<b>16 days</b>		TOWN <b>Rural Charlotte Hall</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>78 ST. MARY'S HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>1</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>Caspay</b> (Middle) <b>Dade</b> (Last)				<b>Nov. 11, 1955</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>Male</b>	<b>Black</b>	<b>Married</b>	<b>March 5, 1889</b>	<b>66</b> yrs.	Months	Days	Hours
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>Laborer</b>		<b>Day work</b>		<b>Maryland</b>		<b>U.S.A.</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>Unknown</b>				<b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
(If Yes, give war or dates of service)				<b>Joseph Dade Charlotte Hall, Md.</b>			
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>522X</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>IMMEDIATE CAUSE (A)</b>				<b>hypostatic pneumonia</b>			
<b>ANTECEDENT CAUSE(S) (B)</b>				<b>pulmonary hbc or</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST</b>				<b>pulmonary metastasis</b>			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>		<b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Nov 5, 1955, to Nov 11, 1955, that I last saw the deceased alive on Nov 10, 1955, and that death occurred at 11:00 A.M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<b>Leon Bente</b>				<b>11/14/55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b>	
<b>Burial</b>		<b>11/15/55</b>		<b>Ebenezena</b>		<b>Charlotte Hall, Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>DATE 11-14-55</b>		<b>Flannell House</b>		<b>John S. Mattingly</b>		<b>Leonardtwn Md.</b>	

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. After this time the bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time the bottom copy may be retained by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11196  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11202  
Reg. Dist.  
No. 281

## 1. PLACE OF DEATH:

COUNTY **St. Marys** MARYLAND  
CITY (If outside corporate limits, write RURAL OR and give nearest town) LENGTH OF STAY (in this place)  
☒ TOWN **R.F.D. Mechanicsville** **6 mo.**  
HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **New Jersey** COUNTY  
CITY (If outside corporate limits write RURAL and give nearest town) OR  
TOWN **Jersey City** **67X-3**  
STREET ADDRESS (If rural, give location)  
**428 New York Ave.**

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

## 4. DATE OF DEATH

(Month)

(Day)

(Year)

(Type or Print)

**Hattie****Kuentzler****Dehrenbach****11 - 24 - 1955**

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday: yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.  
Months Days Hours Min.

**female****white****widowed****12/22/1874****80**

## 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

**housewife****Domestic****Germany****USA**

## 13. FATHER'S NAME:

**Adolph Dehrenbach, Sr.**

## 14. MOTHER'S MAIDEN NAME:

**Christina Kuntzler**

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

**no**

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

**R.F.D. 1 Lake Shore**  
**Adolph Dehrenbach, Jr.- Pasadena, Md.**

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

**420.1**

Immediate cause

(a).....  
DUE TO

Antecedent cause(s)

Diseases or conditions, if any, (b).....  
giving rise to the above cause DUE TO  
stating underlying cause last (c)

*Coronary Occlusion*  
*Arterio Sclerosis*

## INTERVAL BETWEEN ONSET AND DEATH

**1 day**

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

**none**

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

## 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)

## 21c. (City or town)

(County)

(State)

## 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

## SIGNATURE

CHIEF MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒  
M. D. ASSISTANT MEDICAL EXAM. ☐

## DATE SIGNED

**11/25/55**

## 23. BURIAL, CREMATION, REMOVAL (Specify):

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

**11-29-55****P. P. Deane, M.D.**

**Jersey City, New Jersey**  
**P.B. Robinson- Leonardtown, Md.**

**Local**



11197

## CERTIFICATE OF DEATH

Reg. Dist. No. 281

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Marys</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Marys</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X</b> TOWN <b>Beachville</b>		LENGTH OF STAY (in this place) <b>1 wk.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Scotland</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>				STREET ADDRESS (If rural give location) <b>Rural</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>John Alexander Gatton</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>11 / 5 / 19 55</b>			
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>widowed</b>	<b>8. DATE OF BIRTH</b> <b>11 June 1879</b>		<b>9. AGE last birthday</b> <b>76</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>farming</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farm Tenant</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>George Gatton</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Martha Cullison</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> -----		<b>17. INFORMANT &amp; ADDRESS</b> <b>J. Earl Gatton - Dameron, Maryland.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE</b> (A) <b>Coronary occlusion</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>16 minutes</b> <b>5 years</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <b>Coronary sclerosis</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>0</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) <b>M.</b>		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>March, 1953</b> , <b>to</b> <b>11-5</b> , <b>1955</b> , <b>that I last saw the deceased alive on</b> <b>11-4</b> , <b>1955</b> , <b>and that death occurred at</b> <b>9:15 PM</b> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>P. J. Beary M.D.</b>				<b>ADDRESS</b> (Street, city, town, state) <b>Great Mills, Md.</b>		<b>DATE SIGNED</b> <b>11-7-55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>11/8/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St. Michaels Cemetery</b>		<b>LOCATION (City, town, or county)</b> (State) <b>Ridge, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>11/7/55</b>		<b>REGISTRAR'S SIGNATURE</b> <b>P. J. Beary M.D. Secy</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>P. J. Rhinow</b>		<b>ADDRESS</b> <b>Leonardtown, Md.</b>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



11198

11204  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 11204

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:										
COUNTY <b>St. Mary's</b> MARYLAND			STATE <b>Maryland</b> COUNTY <b>St. Mary's</b>										
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Bushwood</b>			CITY (If outside corporate limits write RURAL and give nearest town) TOWN <b>Bushwood</b>										
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)										
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Walter Benjamin Goode</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 25, 1955</b>										
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>Sept. 20, 1896</b>		9. AGE last birthday: <b>59</b> yrs. <table border="1"><tr><td>Months</td><td>Days</td><td>Hours</td><td>Min.</td></tr><tr><td><b>2</b></td><td><b>5</b></td><td></td><td></td></tr></table>	Months	Days	Hours	Min.	<b>2</b>	<b>5</b>		
Months	Days	Hours	Min.										
<b>2</b>	<b>5</b>												
10a. USUAL OCCUPATION (Give kind of work done during most of work life) <b>Tide Water Fishier</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Capt. Police Boat</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>									
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>													
13. FATHER'S NAME: <b>James Henry Goode</b>			14. MOTHER'S MAIDEN NAME: <b>Unknown</b>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>3 No None</b>		16. SOCIAL SECURITY No.: <b>213-22-0243</b>		17. INFORMANT & ADDRESS: <b>Maude Vallandingham Bushwood, Md.</b>									

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a)..... <b>420.1 Coronary occlusion</b>		DUE TO			
Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause		DUE TO			
stating underlying cause last (c)					
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>rickets of liver</b>					
19a. DATE OF OPERATION: <b>none</b>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <b>none</b>		21c. (City or town) (County) (State) <b>none</b>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>none</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>none</b>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <b>[Signature]</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11/25/55</b> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>11/28/55</b>		NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>	
LOCATION (City, town, or county) (State) <b>Bushwood, Maryland</b>		24. FUNERAL DIRECTOR <b>Jos. C. Mattingley Leonardtown, Md.</b>			
DATE REC'D BY LOCAL REG. <b>11-28-55</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

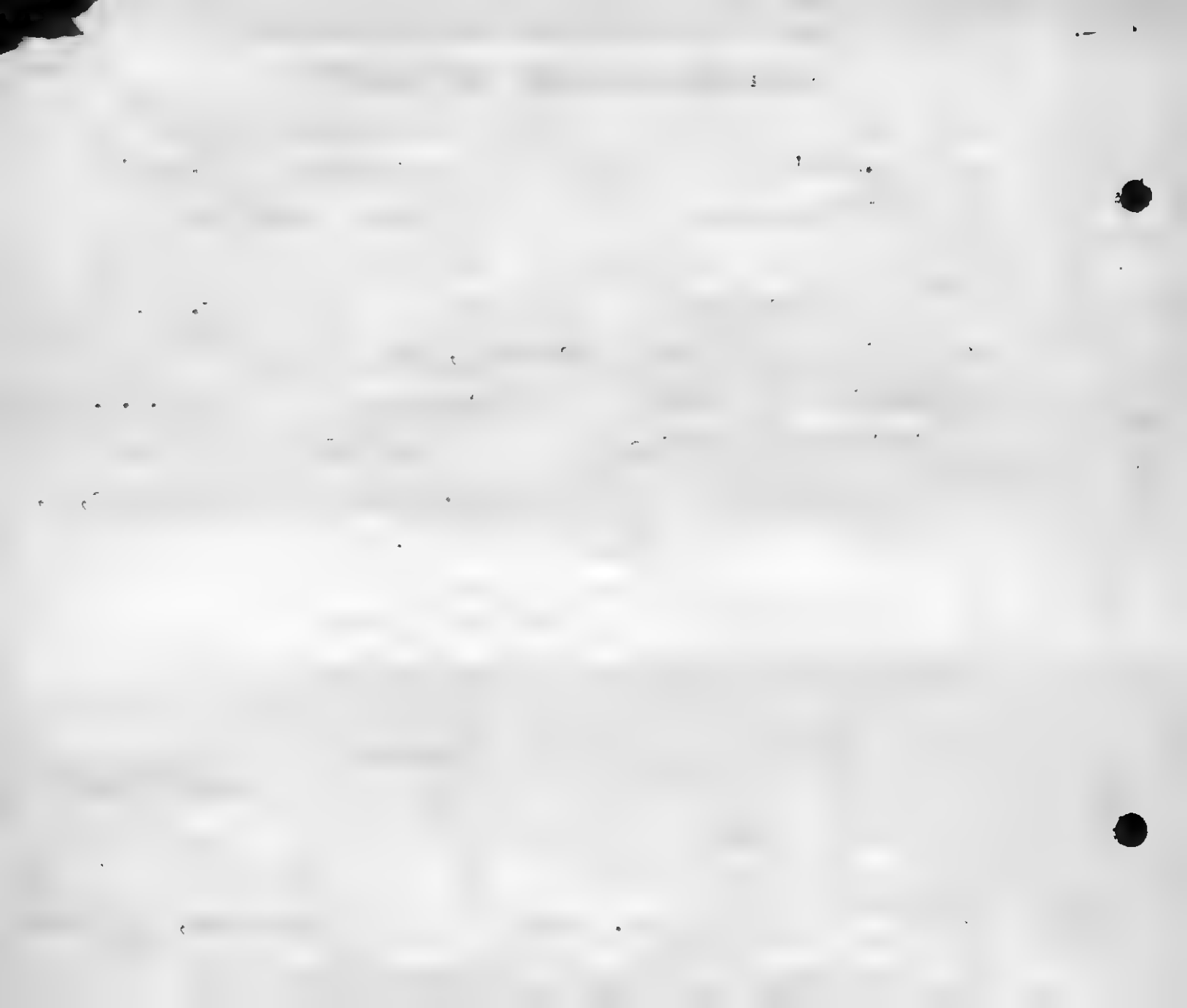
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11199 CERTIFICATE OF DEATH

11205

Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>St. Mary's</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Mary's</b>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
X TOWN <b>Rural Leonardtown</b>		<b>Life</b>		X TOWN <b>Rural Leonardtown</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)			
<b>Georgiana</b>		<b>Guy</b>		<b>Nov. 5, 1955</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
<b>Female</b>	<b>White</b>	<b>Widowed</b>	<b>October 9, 1865</b>	<b>90</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Housewife</b>		<b>Home</b>		<b>Maryland</b>		<b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MARDEN NAME			
<b>William Thomas Cullins</b>				<b>Jane Raley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<b>MR. THOMAS GUY Leonardtown, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4. IMMEDIATE CAUSE (A) <b>Cerebral Thrombosis</b>						<b>12 hr</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Arteriosclerotic Cardiovascular disease</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						<b>20 yrs</b>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan 1950</b> to <b>Nov 5, 1955</b> , that I last saw the deceased alive on <b>Nov 4, 1955</b> , and that death occurred at <b>8:30</b> M., from the causes and on the date stated above.							
SIGNATURE <b>J. Roy Guyther</b>		M.D. <b>Richardsville</b>		DATE SIGNED <b>11/8/55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>11/8/55</b>		NAME OF CEMETERY OR CREMATORY <b>St. Aloysius</b>		LOCATION (City, town, or county) (State) <b>Leonardtown, Maryland</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <b>Glenn S. Hauser</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. L. Mattingly</b>		ADDRESS <b>Leonardtown, Md</b>	
DATE <b>11-8-55</b>							



## 11200 CERTIFICATE OF DEATH

Reg. Dist. No. 282

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Mary's</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Mary's</b>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <b>Compton</b>		LENGTH OF STAY (in this place) <b>Life</b>		CITY (If outside corporate limits, write RURAL end give nearest town) <b>Compton</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Compton</b>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) (Middle) (Last) <b>Joseph Matthew Hazel</b>				<b>Nov. 5, 1955</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>May 25, 1883</b>	<b>9. AGE last birthday</b> <b>72</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>5</b> Days <b>11</b>	<b>IF UNDER 24 HRS.</b> Hours <b>11</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Storeowner</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Gen. Mdse.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>John J. Hazel</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie Lewis</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs Eva Alvey Leonardtown, Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>1a. IMMEDIATE CAUSE (A)</b> <b>Carcinoma larynx</b>							
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>							
<b>(B) DUE TO</b>							
<b>(C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
		<b>M.</b>					
<b>22. I hereby certify that I attended the deceased from Feb 1952, to Nov 5, 1955, that I last saw the deceased alive on Nov 4, 1955, and that death occurred at 6:30 M, from the causes and on the date stated above.</b>							
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>DATE THEREOF</b> <b>11/9/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St. Francis Xavier</b>	
				<b>LOCATION (City, town, or county)</b> <b>Compton, Maryland</b>		<b>DATE SIGNED</b> <b>11/18/55</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <b>James S. Hauser</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John C. Mattingly</b>			
<b>DATE</b> <b>11-8-55</b>				<b>ADDRESS</b> <b>Leonardtown, Md.</b>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled in by the funeral director, the third copy of this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11207

## 11201 CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>St. Mary's</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>St. Mary's</u>
CITY (if outside corporate limits, write RURAL and give nearest town) <u>U.S. NAS</u>	LENGTH OF STAY (in this place) <u>16 hrs. 25 min.</u>	CITY (if outside corporate limits, write RURAL and give nearest town) <u>Patuxent River, Md.</u>	TOWN <u>Patuxent River, Md.</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Air Station Hosp. Patuxent River, Maryland</u>	STREET ADDRESS <u>34900 Glenwood Road</u>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <u>Baby</u>	(Middle) <u>Boy</u>	(Last) <u>HOWELL</u>	<u>Nov 9 1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Specify): <u>single</u>	8. DATE OF BIRTH: <u>Nov 3 1955</u>
9. AGE last birthday: <u>2</u> yrs <u>2</u> months <u>2</u> days <u>2</u> hours <u>2</u> min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Franklin M. HOWELL</u>		14. MOTHER'S MAIDEN NAME: <u>Bernice Mary Summers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>Yes</u>		16. SOCIAL SECURITY NO. <u>17-109 Yorktown Rd. Lexington Park, Maryland</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Prematurity, Neonatal Death (27 weeks gestation)</u>		<u>15 hours 25 minutes</u>	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION <u>11-10-55</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11-10-55</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8 Nov 1955</u> , to <u>9 Nov 1955</u> , that I last saw the deceased alive on <u>9 Nov 1955</u> , and that death occurred at <u>1150 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>E. J. Irgens</u>		DATE SIGNED <u>11-10-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		24. FUNERAL DIRECTOR	
DATE REC'D BY LOCAL REGISTRAR <u>11-10-55</u>		ADDRESS <u>Station Hospital, NAS Patuxent River, Md.</u>	
REGISTRAR'S SIGNATURE <u>P. J. Bean, M.D.</u>		LOCATION (City, town, or county) (State) <u>Great Mills, Maryland</u>	



## 11202 CERTIFICATE OF DEATH

Reg. Dist. No. 282

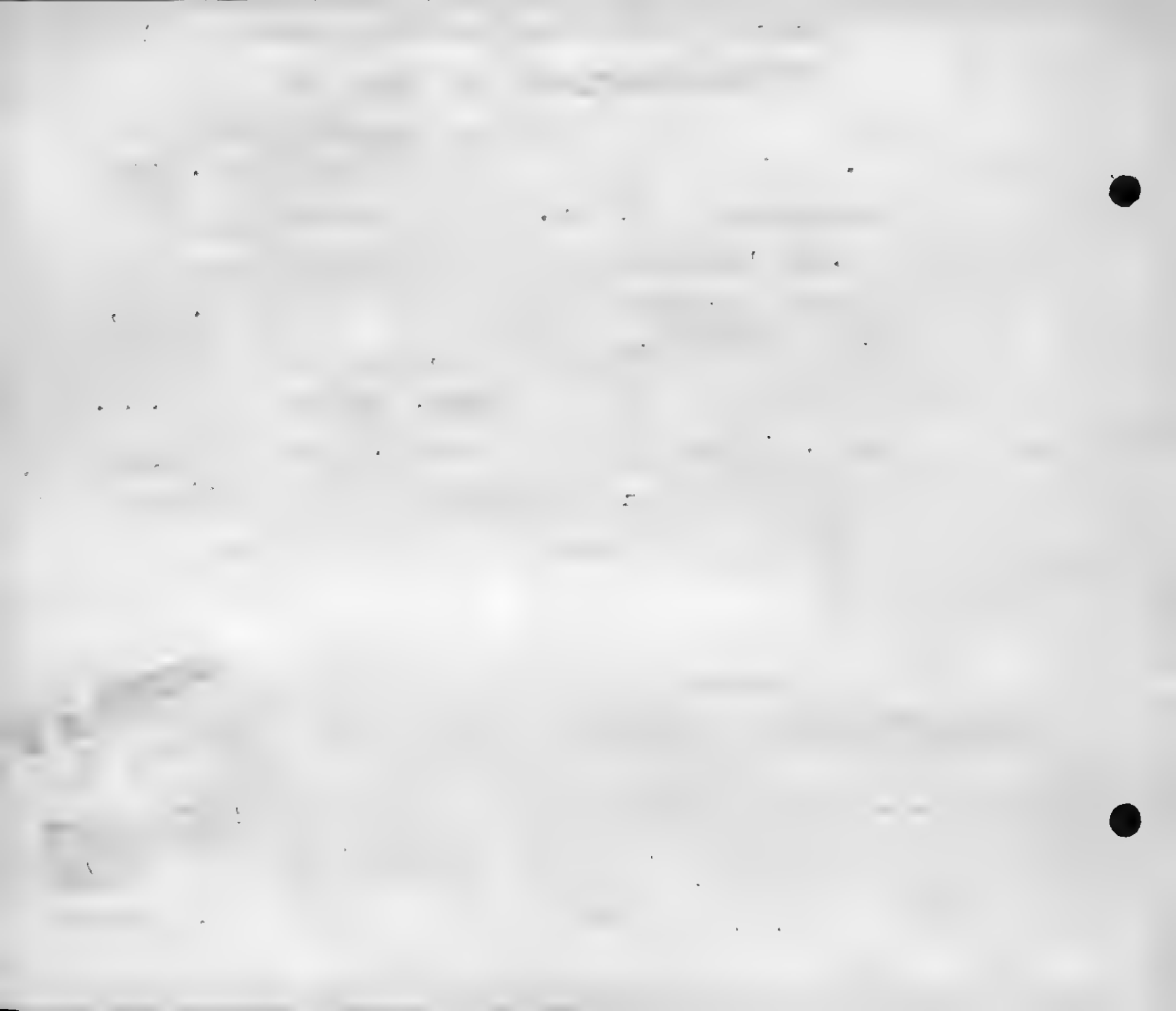
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>St. Mary's</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Mary's</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Leonardtown</b>		<b>12 hrs.</b>		TOWN <b>Lexington Park</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>St. Mary's Hospital</b>				STREET ADDRESS (If rural give location) <b>327 Yorktown Road</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <b>Tell William Nicolet</b>				(Month) (Day) (Year) <b>Nov. 20, 1955</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Male</b>	<b>White</b>	<b>Married</b>	<b>October 17, 1890</b>	<b>65</b> yrs.	Months <b>1</b>	Days <b>3</b>	Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Band Planner</b>				<b>Desota, Indiana</b>		<b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Luke A. Nicolet</b>				<b>Annie D. Casper</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		327 Yorktown Rd.	
<b>Yes</b>		<b>WWI</b>		<b>172 - 14 - 0095</b>		<b>Mildred Nicolet Lexington Park, Md</b>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <b>Dissecting aneurysm - aorta</b>							
ANTECEDENT CAUSE(S) DUE TO (B) <b>Arteriosclerotic CV disease</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Nov 19, 1955</b> to <b>Nov 20, 1955</b> , that I last saw the deceased alive on <b>Nov 20, 1955</b> , and that death occurred at <b>2:50 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Roy Gwyther</b>				ADDRESS <b>Mechanicville, Md</b>		DATE SIGNED <b>11/21/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>11/22/55</b>		<b>Poplar Hill</b>		<b>Valley Lee, Maryland</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <b>11-22-55</b>		<b>James H. ...</b>		<b>James H. ...</b>		<b>Leonardtown, Md.</b>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# 11203

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11209  
Reg. Dist. No. 282

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <b>St Mary's</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>St. Mary's</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <b>Rural Bushwood</b>		<b>Life</b>		TOWN <b>Rural Bushwood,</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
<b>3. NAME OF DECEASED:</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>Johnson Bruce Quade</b>				<b>Nov. 14, 1955</b>			
<b>5. SEX:</b>		<b>6. COLOR OR RACE:</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED.</b>		<b>8. DATE OF BIRTH:</b>	
<b>Male</b>		<b>White</b>		<b>Single</b>		<b>1922 33 yrs.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of work life, even if retired): <b>Labor</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY:</b>		<b>11. BIRTHPLACE</b> (State or foreign country): <b>Maryland</b>	
						<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME:</b> <b>Bruce Johnson Quade</b>				<b>14. MOTHER'S MAIDEN NAME:</b> <b>Rose Milburn</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY No.:</b>		<b>17. INFORMANT &amp; ADDRESS:</b> <b>Bruce Johnson, Hurry, Maryland</b>	
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>							<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>322.2</b> <b>Immediate cause</b> (a) ... <b>Pulmonary edema</b> DUE TO <b>Antecedent cause(s)</b> (b) ... <b>multiple trauma</b> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) ... <b>subdural laceration due to Alcoholism</b>							<b>medic.</b>
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>none</b>							
<b>19a. DATE OF OPERATION:</b> <b>none</b>				<b>19b. MAJOR FINDING OF OPERATION:</b> <b>none</b>			
<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:</b>		<b>21b. PLACE</b> (Home, farm, factory, street, office bldg., etc.) OF INJURY: <b>none</b>		<b>21c. (City or town), (County) (State)</b> <b>none</b>			
<b>21d. TIME</b> (Month) (Day) (Year) (Hour) OF INJURY: <b>none</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <b>none</b>			
<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input checked="" type="checkbox"/>.</b>							
<b>SIGNATURE</b> <i>[Signature]</i>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>11/14/55</b> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAM.</b> <input type="checkbox"/>			
<b>23. BURIAL, CREMATION, REMOVAL</b> (Specify): <b>Burial</b>		<b>DATE THEREOF</b> <b>11/15/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Sacred Heart</b>		<b>LOCATION</b> (City, town, or county) (State) <b>Bushwood, Maryland</b>	
<b>DATE REC'D BY LOCAL REG.</b> <b>11/14/55</b>		<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		<b>24. FUNERAL DIRECTOR</b> <b>Jos. C. Mattingley Leonardtown, Md.</b>			



## 11204 CERTIFICATE OF DEATH

Reg. Dist. No. 231

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Marys</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Marys</b>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X TOWN Piney Point Beach</b>		LENGTH OF STAY (in this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X TOWN Piney Point Beach</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>08</b>				STREET ADDRESS (If rural give location) <b>Pine Lodge</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>Alfonso</b> (Middle) <b>Rossi</b> (Last)				<b>Nov 3, 1955</b>		19	
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>married</b>	<b>8. DATE OF BIRTH</b> <b>7/12/1900</b>	<b>9. AGE last birthday</b> <b>55</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired violinist</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Nat. Symphony</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Italy</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Giovanni Rossi</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Giovanna Rastelli</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>579-16-9402</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Ida Rossi</b> <b>Piney Point Beach, Md.</b>		<b>Wife</b>	
<b>18. MEDICAL CERTIFICATION</b>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>150X IMMEDIATE CAUSE (A)</b> <b>Carcinoma of esophagus</b>						<b>4 months</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO</b>							
<b>STATING UNDERLYING CAUSE LAST.</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Coronary heart failure</b>						<b>4 months</b>	
<b>19a. DATE OF OPERATION</b> <b>June 13, 1955</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>metastatic carcinoma of esophagus</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, lecture, or INJURY street, office bldg., etc.)</b> <b>none</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b> <b>none</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b> <b>none</b>		<b>21a. INJURY OCCURRED</b> While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21i. HOW DID INJURY OCCUR?</b> <b>none</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>Sept. 6, 1955</b> , to <b>Nov. 3, 1955</b> , that I last saw the deceased alive on <b>Nov 2, 1955</b> , and that death occurred at <b>2:20 PM</b> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <b>Dr. R. J. Benning</b> M.D.				<b>ADDRESS</b> (Street, city, town, or county) <b>2901 14th St. NW</b>		<b>DATE SIGNED</b> <b>11/3/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>burial</b>		<b>DATE THEREOF</b> <b>11/7/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Rock Creek Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Washington, D.C.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>Nov 7, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Dr. R. J. Benning</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Thos. H. Wines Co</b>		<b>ADDRESS</b> <b>2901 14th St. NW</b> <b>Washington, D.C.</b>	

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this

certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this

death certificate assembly should be detached for use as a burial transit permit.

VS-115C 1-55 101A



## 11205 CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>St. Marys</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Marys</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>St. Inigoes</b>		LENGTH OF STAY (In this place) <b>life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>St. Inigoes</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00 Rural</b>				STREET ADDRESS <b>Rural</b>		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Katherine</b> (Middle) <b>Rosalice</b> (Last) <b>Taylor</b>				(Month) <b>11</b> (Day) <b>29</b> (Year) <b>55</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>10/ 20 / 1875</b>	9. AGE last birthday <b>80</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Dominic Raley</b>				14. MOTHER'S MAIDEN NAME <b>Alice Tarelton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT & ADDRESS <b>Mrs. Alice Knott - St. Inigoes, Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
334X IMMEDIATE CAUSE (A) <b>Cerebral arterio-sclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>57 years</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Generalized arterio-sclerosis</b>				<b>10 years</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Feb 18, 1955</b> to <b>Nov 29, 1955</b> , that I last saw the deceased alive on <b>Nov 28, 1955</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.							
SIGNATURE <b>A. B. Rubiner</b>				ADDRESS (Street, city, town, state) <b>Great Mills Md</b>		DATE SIGNED <b>11/30/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>12/2/55</b>		NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>		LOCATION (City, town, or county) <b>Ridge, Maryland.</b>	
24. REC'D BY REGISTRAR DATE <b>Nov 30/55</b>		REGISTRAR'S SIGNATURE <b>A. B. Rubiner</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>A. B. Rubiner</b>		ADDRESS <b>Leonardtown, Md.</b>	

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 Hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly shall be detached for use as a burial transit permit.

VS A15C 1-55 10M

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11206

## CERTIFICATE OF DEATH

Reg. Dist. No.

11212  
281

1. PLACE OF DEATH COUNTY <b>St. Mary's</b> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <b>U.S. NAS</b> LENGTH OF STAY (in this place) TOWN <b>Patuxent River, Md.</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>U.S. Naval Air Station Hosp. Patuxent River, Maryland</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>St. Mary's</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park, Maryland</b> STREET ADDRESS (If rural give location) <b>633 Chinlee Drive</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Baby Boy WATSON</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>Nov 29 1955</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>Caucasian</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>Nov 27 1955</b>
9. AGE last birthday: <b>2</b> yrs Months Days Hours Min.		10. BIRTHPLACE (State or foreign country): <b>Maryland</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
11. FATHER'S NAME: <b>Lloyd C. Watson</b>		12. MOTHER'S MAIDEN NAME: <b>Doris Anne Watts</b>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):		14. SOCIAL SECURITY NO.:	
15. INFORMANT & ADDRESS: <b>Lloyd C. Watson 633 Chinlee Dr. Lexington Park, Md.</b>		16. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
17. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>776X IMMEDIATE CAUSE</b> <b>Antecedent Cause (S)</b> <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>		18. MEDICAL CERTIFICATION (A) <b>Prematurity, Neonatal Death</b> DUE TO <b>(36 weeks gestation)</b> (B) DUE TO (C) DUE TO	
19. DATE OF OPERATION:		20. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>27 Nov, 1955</b> , to <b>29 Nov, 1955</b> that I last saw the deceased alive on <b>29 Nov, 1955</b> , and that death occurred at <b>6.08 AM</b> , from the causes and on the date stated above. SIGNATURE <b>A. I. Feldman</b> ADDRESS <b>Station Hospital NAS Patuxent River, Maryland</b> DATE SIGNED <b>29 Nov 1955</b> <b>A. I. FELDMAN LT MC USNR</b> M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		24. FUNERAL DIRECTOR ADDRESS	
DATE REC'D BY LOCAL REGISTRAR <b>Nov 29/55</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>	



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11207 **CERTIFICATE OF DEATH**Reg. Dist. No. 282

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Marys</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Marys</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <b>Leonardtown</b>		<b>4 wks.</b>		OR TOWN <b>Lexington Park</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>St. Marys Hospital</b>				STREET ADDRESS (If rural give location) <b>31 Coral Place</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <b>Carl</b> (Middle) <b>Edward</b> (Last) <b>Wilkins</b>				<b>11 - 13 19 55</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>male</b>	<b>white</b>	<b>widowed</b>	<b>19 April 1906</b>	<b>49</b> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<b>Cab Driver</b>			<b>Taxi</b>		<b>West Virginia</b>		<b>USA</b>
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>Unknown</b>				<b>Lottie Shippe</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)</b>			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>		
<b>no</b>					<b>31 Coral Place Eugene H. Wilkins- Lexington Park, Md.</b>		
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>581.0 IMMEDIATE CAUSE (A)</b>						<b>Cirrhosis of Liver</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>						<b>6 weeks.</b>	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<b>6 weeks.</b>	
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>none</b>				<b>none</b>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>			<b>21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		
<b>none</b>			<b>none</b>		<b>none</b>		
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>			<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>		
<b>none</b>			<b>M. at work</b>		<b>none</b>		
<b>22. I hereby certify that I attended the deceased from 10/11/55, 1955, to 11/13/55, 1955, that I last saw the deceased alive on 11/12/55, 1955, and that death occurred at 12 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<b>James M.D. Lexington Park, Md.</b>				<b>11/13/55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>Burial</b>		<b>11/16/55</b>		<b>St. Johns Cemetery</b>		<b>Ellicott City, Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>11/14/55</b>		<b>Charles A. House</b>		<b>BB Robinson</b>		<b>Leonardtown, Md.</b>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this

certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this

death certificate assembly should be detached for use as a burial transit permit.

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4. *Journal of the American Statistical Association*, 1991, 86, 1039-1042.

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11214

## 11208 CERTIFICATE OF DEATH

Reg. Dist. No. 282

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Marys</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Marys</b>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <b>X</b> TOWN <b>Laurel Grove</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Charlotte Hall,</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>58 Rural</b>				STREET ADDRESS (If rural give location) <b>Rural</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>Thomas</b>		(Middle) <b>Andrew</b>		(Last) <b>Woodland</b>		(Month) (Day) (Year) <b>11/ 28 / 19 55</b>	
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>colored</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>married</b>	<b>8. DATE OF BIRTH</b> <b>10/6/1908</b>		<b>9. AGE last birthday</b> <b>47</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>tenant</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farm</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>William Woodland</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Bertha E. Dent</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>-----</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Bertha E. Woodland - Charlotte Hall, Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>191X IMMEDIATE CAUSE (A)</b> <b>Cachexia</b>							
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Carcinoma toxic - origin unknown</b>						<b>1 yr</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, (C)</b> <b>in perineal sweat gland</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>1 June 1955</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>metastasis from carcinoma</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
		<b>M.</b>					
<b>22. I hereby certify that I attended the deceased from May 19 55, to Nov 28, 1955, that I last saw the deceased alive on Nov 28, 1955, and that death occurred at 1:30 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>John Guyton</i>				<b>ADDRESS</b> (Street, city, town, state) <i>Mechanicville</i>		<b>DATE SIGNED</b> <i>11/28/55</i>	
<b>23. BURIAL, CREMATION REMOVAL (Specify)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>11/30/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St. Joseph Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Morganza, Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Alan D. Harvey</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>P.B. Robinson</i>		<b>ADDRESS</b> <i>Leonardtown, Md.</i>	
<b>DATE</b> <i>12/1/55</i>							

DEATH CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Residence		Manner of Death	
Signature of Physician		Signature of Coroner		Signature of Registrar	
Date of Report		Place of Report		Signature of Registrar	

BUREAU V. S.

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